

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

August 21, 2018

Ms. Tonia Trask, Manager Wintergreen Residential Care - North 540 Town Farm Rd Brandon, VT 05733

Dear Ms. Trask:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 17, 2018**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

amlaMCotaPN

Disability and Aging Services Licensing and Protection



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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August 1, 2018

Tonia Trask, Manager Wintergreen Residential Care - North 540 Town Farm Rd Brandon, VT 05733

Dear Ms. Trask:

The Division of Licensing and Protection completed a re-licensing survey and investigation of an incident at your facility on July 17, 2018. The purpose of the survey was to determine if your facility was in compliance with Vermont Residential Care Home Regulations. The survey statement is enclosed. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy. You must submit a plan of correction. Please write/type the Plan of Correction in the space provided on a tach a separate document. A completion date for each plan of correction must be indicated.

Please sign, date, and indicate your little on the bottom of the first page of the report and return this report to this office no later than August 14, 2018.

Your POC must contain the following:

- What action you will take to entrect the deficiency;
- What measures will be put into place or what systemic changes you will make to ensure into the deficient practice does not recur and,
- How the corrective actions will be monitored so the deficient practice does not recur.
- The dates corrective action will be completed.

Disability and Aging Services Licensing and Protection Blind and Visually Imparied Vocational Rehabilitation

manager. 8/8/18

PRINTED: 08/01/2018

Division of Licensing ar	nd Pro	tection		90			FORM APPROVED
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	1000	(X1) PROVIDER/SUR IDENTIFICATION	IL R	CLIA	F 50 - 6	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN OF CORRECTION		DENTIFICATION	TI BVI	JEK,	A, BUILDING	·	
		0619			B. WING	The state of the s	C 07/17/2018
NAME OF PROVIDER OR SUF	PLIER			STREET	DORESS, CITY,	STATE, ZIP CODE	
WINTERGREEN RESIDE	ENTIA	L CARE - NORTH	911 1 119	-	VN FARM RD		
		imi i		BRAND	ON, VT 0573		
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		n-site re-licensure livision of Licensir			Î		~ 1~
Protection on	7/17/	18. The survey al:	do in	cluded		The action take	
regulatory rev	riew o	f a facility mandat	ry		,	Correct the defic	iencuis 1
; self-report. Ti	here v	f a facility mandat vere no violations ollowing violation	ela	ed to ti	ie:		
related to the	re-lice	onowing violation: ensure survey.	We	le 	i	to update care	2 PIQUIS
						immediately as	s the
R145 V, RESIDEN	T ÇAF	RE AND HOME SI	W	CES	, R145		
SS=D						Changes occur for	or each [
5.9.c (2)						resident.	
5000-99-00-00-00-00-1 -0 -0-00- 0 -00						CS(COLIVE)	
Oversee deve	elopm	ent of a written pl s based on abilitie resident assessm	hΙα	care f	or .		حامرا
each resident as identified i	t that i	s based on abilitie resident assessm		A plan	IS.	The measures p	ut und
of care must	descri	be the care and	rvi	es		The measures proposed to ensure	this doesn't
necessary to	assist	the resident to m	aint	in		Fide to choose	Man managa
independence	e and	well-being;				recur will be	THE mainte
						& RN WILL WORK	-toaether I
1_				1000			
This REQUIR by:	REME	VT is not met as	Ma	nced.		as changes occ	m to ensure
	ff inter	view and record	evie	w. the		care plans are	alwayis
RN (Register	ed Nu	rse) failed to assi	et	at the			- Car any 5
care plan for	1 of 3	residents in the	用中的	e was		updated.	# E
		a change in medi ings include:	a s	atus.			
(**************************************						The corrective	olations will
Per record re	view c	on 7/17/18, Reside	ht #	3 was			
edmitted to m	ospici s not r	e Services (5/16/1		nd the		be monitored r	nonthly by
the changes i	in phy	evised at that tim sician orders for c	Bint	ort care		the manager	1 /
and any resid	ent ch	ranges in conditid	H. P	er	Š.	11.33100001	4
Interview with	ithe fa	current RN was	12	ner at	5	The corrective	e actions
end of June.	2018.	current RN was and the previous	RN.	nad nor	li li	will be complet	
revised the re	esiden	t's care plan.		7.5		man August 13.	2018
Division of Licensing and Prote ABORATORY DIRECTOR'S OR	ection	SER/SURPLIED DEPO	<u> </u>	ATIMES S	uchati id e	550.18 MB15	(X6) DATE
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Division	of Licensing and Pro						
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		0619			8. WING _		C 07/17/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET	ODRESS, CIT	Y, STATE, ZIP CODE	
WINTER	GREEN RESIDENTIA	CARE NORTH		111	WN FARM F		
					ON, VT 057		
(X4) ID PREFIX YAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENY OF DEFICIEN MUST BE PRECEDED SCIDENTIFYING INFO	Sign Frank F	ULL ION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CRDSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
R150 SS=D	V. RESIDENT CAR	REAND HOME SE	RV	CES	R150	RISO: The action to C deficiency is t	orrect the
	5.9.c (7)						
	Assure that sympto accident are record along with action to	led at the time of	ess	or rence		to record resi	dont charts
	This REQUIREME		ev d	enced		accidents, at the	e time of
0	by: Based on staff inte facility RN failed to illness or accident	rview and record assure that symp	e vie	v, the	R.	occurrence, alc	ng with
	occurrence, along the sidents in the sidents in the sidents in the sidents in the sidents include:	with the action(s)	ll H∈	for 2	of)	actions taken, apts & progre	
	Per record revier record had a progridesident Name' giverror'. There was not a progride to the progrides of the progrides.	w on 7/17/18, Res ess note dated 3/ ven 2 doses of a	vie: 28/1 10e(it #2's 8 statin cation	g in	measures put or make sure this	to place to doesn't recu
	action was taken, v	vhether the reside	tiv	#15	}	are; the RN u	sill check chai
-	monitored for signs adverse drug react most recent note in no further notes we	the record was f	end end	etc. The 4/8/18,	* ***	to document w	th falls, or ap
	2. Per record review note date 4/8/18 st	ated that the resid	Hot	had a fa	au a	meds, ect.	. 1
	and hit h/her head evaluation. The res later the same high	and was sent to the ident returned to it. The note said the	e E	D for an acility		Corrective action	
	was checked and (safe. The discharg- instructed staff to r primary care provide	DK, stable vital sit	Mg a	and is		montitured mon manger.	AIN DO THE
\$\$\delta\$	primary care provide progress notes in the date; there was no monitoring nor a pl	he resident's reco	r s	nce tha	t	the date correct	ive actions
Nata er		rysician visit since	Me	eturn		twill be completed	by 15
ivision of Li TATE FOR	censing and Protection M				5872	92RITE AUGUST 13, 20	Dontinuation sheet 2 of 8
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Divicion o	f Licensing and Pro	stection					TOMWA: THOVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUP	HER	CLIA	(X2) MULTIPL	E CONSTRUCTION .	(X3) DATE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION	UMUMI	BER:	A. BUILDING:		COMPLETED
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161		0619			B. WING	- LANGE COMMENTS	07/17/2018
NAME DF PI	ROVIDER OR SUPPLIER	**	MI.	TREET	DDRESS, CITY, 9	STATE, ZIP CODE	
MANTEDO	DEEN BEGIBENTIA	CARE NORTH		40 TO	WN FARM RD		10
WINTERG	REEN RESIDENTIA	L CARE - NORTH		RAND	ON, VT 05733	,	
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		****		ļ		DEFICIENCY)	
R150	Continued From pa	age 2			R150	RIGH	
	from the ED on 4/8	DATABUR-				KIW-I	to carrent
	HOM THE ED ON 470	110.				The action taken	10 Correct
	The lack of docum-	entation of follow	up a	tions	fo.	Boo doficianci	is the pal
	regarding accident	s and/or changes	M to	ndition		The delicality	15) INC-KIN
	was confirmed and the owner on 7/17/		ter	lew wi	n	the deficiency will assure so	afficent
	Refer also to R 189					olasci paratationa	A transport
	-				5.47	documentation	
	V. RESIDENT CAR	RE AND HOME S	RV	CES	R164	for all new me	dication
SS=D							
	5,10 Medication N	Management	∭,			technicions as	well as
	0.70	vicinagerneric					
	5.10.d If a resident	requires medical	i in			re-certifing a	11 Curein
B 10	administration, unli medications under				-8	Staff.	g 1
	medications under	THE TONOWING COM			1		1 2 4
	(2) A registered nu					The RN Will K	on a folder
	responsibility for the medications to des					INE KN WIN B	dep in control
	residents	signated stail for t	y siy	lateu .		with all train	ings, names
ľ	In vertical course					Lados tosts for	Thou + Cuerte
	This REQUIREME	NT is not met as	evid	nced		dates, tests for medication tech	note -
	by: Based on staff inte	rview and record	revie	w. the		medication tech	MUTUAS TO
	facility RN failed to	assure sufficient	Ш	17.52	(9)	ensur this doe	soit recut.
	documentation of t	raining for a new	Med	cation		ienous this one	
	Technician (MT) w medications to res	no was administe	1119.	ring the		¥.	2
	survey. Findings in			ing tile	1	corrective action	ns will be
	1						140 01)
	Per interview with	the MT who was	inti	isterin	9	monitored by so this doesn't	the kin
1	medications on the described the production	e atternoon of 7/1		S/ne MT at		SO this dancin	+ CPCUL.
	the facility as follow	ws: the MT stated	mat	she ·		-0 ms acesn	1.00.
	the facility as follow started training by	observing anothe	MT	at the	,		me will be
	facility for 1 - 2 we	eks. (Note: s/he h	開口口	#t met	hn.	corrective actual completed by Al	713 61
	nor spoken with the period). The staff is	member stated th	all the	v then	יי	cumpicaled by A	Must 13 2018
1	parious, the elemen			1 2,511		completed by the	yus in

and the second s	or element and Pro		Щ				<u> </u>	
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NAME OF	PROVIDER OR SUPPLIER	100000000000000000000000000000000000000		CTOCCT	ADDRES	e orry	STATE VIDEOUS	1 07/17/2018
						RM RD	STATE, ZIP CODE	
WINTER	GREEN RESIDENTIA	L CARE - NORTH		111		КМ КО Г 05733		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIE	MIRS		111, 1			****
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R164	Continued From pa	ge 3			· R1	64		
	did a medication pa	ess with the RN of		P.C			_	₩ V
	then s/he took a wr	itten medication to	H.	er				∰ ∰
	review of the perso	nnel file for the st	aff n	ember				
	the medication test	had not been gra	ded	nor			**	
	signed by the RN o	n the date taken.	the	e was			9.	
	signed by the RN o no evidence in the	file that the RN he	d de	emed			0.00	:.e:
	the staff member of	ompetent to admi-	ste	ř	1		R189	
	resident medication	15.			2.0		The to the o	to concord
	Mhon the liet of me	المادادات ومناهدالم		ļ.,	l		The action taken	10 COLLECT
	When the list of me requested from the	owner the list per	SI	m was			110 1.01 011	a Ino Staf
	included a signed d	ated signature of		u reviou			the deficiency is	2 the sint
	RN; there was no d	ocumented evide	ch	f the I	st.		RN, and marked	or are to
	included a signed d RN; there was no d of staff med-delega	ted by the new RI	as	of the	1			
	date of survey.	100	III I				record any cho	n 2000
	During interview wit 4:PM on 7/17/18, it RN signature nor da	h the RN and the	pwn	er at	3			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	4: PWI on 7/17/18, it	was confirmed th	r¢ y	as no	i i		a residents co	ndition such
	and no written infor	mation available	nie	eted	16		Os bulgarilla	ind to
	medication delegati	on training provid		thic	1		as, but not lim	THU 105 TO
	staff member. The	new RN had not n	OV	led a li	R†			
	of the staff she had	trained for media	ation	- vi		Ú.S.	medications, hos	PUTAL VISA
	administration since	beginning work	t the	facilit	ļ i		1+1 in 160 0000	200 00100
	in June.	*	-			ļ	etc in the prog	1672 HORD"
0.400	4					i		
\$\$=E	V. RESIDENT CAR	EAND HOME S	RVI	ES	R18	ENERGY .	, , , , , , , , , , , , , , , , , , ,	<u>.</u>
- OO-E						1 - 1	measures put in	to place st
	5.12.b. (3)							
	5					į	this doesn't recu	is are the
	For residents requiri	ing nursing care	die	dina		i		1
	nursing overview or	medication mana	den	ent th	е .	İ	manager will ch	OCV Chart
	record shall also con	ntain: initial asses	drha	st.		ļ	, ()	
	annual reassessmer assessment, physici	nt; significant ch	ge	*			notes weekly for	1 nodated
	assessment, physici	ian's admission 🕏	her	nent		į	The second control of	The state of the s
	and current orders; changes in the resid	staff progress not	eg i	cluding	3	į	documentation.	in progress
	changes in the resid taken; and reports o	f physician vicite	r an	non		İ	notes.	, 0
	telephone orders an	d treatment doc		ation:			IWHO.	
			[[]]	accon,		1	De aunt 8.20.18	MB ISI
	censing and Protection					7	0:00.18	10,184
ATE FORM	48	10			8899	9	ZRi11	if continuation sheet 4 of 8

Division	of Licensing and Pro						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		RVCLIA MBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		9					C
		0619	Ш	║	B. WING		07/17/2018
NAME OF	PROVIDER OR SUPPLIER	77.0524		TREET	ADDRESS, CITY.	STATE, ZIP CODE	1/1
				1111	WN FARM RD		
WINTER	GREEN RESIDENTIA			RAND	ON, VT 0573		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENT MUST BE PRECEDED SC IDENTIFYING INFO		5 = LLL TON)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
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14.193	Continued From pa	ige 4			R189	R189	
	and resident plan o	f care.					
		Management of the Act				12 no potion	nc tilill "
	This REQUIREMEN	NT is not met as	evic	lenced		Whomen be all 10	12 M.
	by:			14		he manitomed	Du-the
	Based on staff inter	view and record		w, the		DE MONTIONED	Jun 54 . 15
	facility failed to assure resident included at	are that the recor		each		LON MONTHUM TO	ensu
	resident included st changes in conditio	in for 2 of 3 reside		in the		TEN MORE TO	Inden't
	sample. Findings in					corretive action be monitored an monthly to this practice of	WESTVI
	10 VP. — 100 St. 1					17.60	
	 Per record review 	v on 7/17/18, Res	ille)	nt#2's	l	recur,	į.
	record had a progre				1		1
	'Resident (name) w				7 .	to a lala 0556	ortille
	medication in error	; there was no fol	YIII.	up note		The deate corraction will be	earn.
	to state what action resident was monitor			ine	:	001 111 100	morador
	symptoms of an ad	vetse drug reacti	MI.	and for	H	Laction will be	composito
	how long etc. The r	ext progress not	Mn'	the		is august 13,	anid
	how long etc. The record was from 4/8	3/18, and docume	te	da fall	10.1	is (manst 13)	0018.
	with a potential hea	d injury. There w	արա	ofollow	-	15 coogus.	· ē
	up note for this acc	ident in the record	圳市	nere hav	ke '		
	been no further pro		#11	this	1 19 12		
	resident since 4/8/1	8.		1			
	2 Per record review	v for Resident #3		TOOTOGO			
	note dated 4/8/18 w	as a follow up to	M-F	ingless			
	2. Per record review note dated 4/8/18 w resident sustained of	on 4/7/18. The re-		n was	o 4º		
	found on the floor in	their room and s	. Hi	to the	- 3		
	ED for an evaluation	n. The follow up r	the.	written			
	4/8/18 was the last	one written as of	the	date of			
	survey 7/17/18. The	re were no progr	e#s	notes		<u>i</u>)E
	since that time to do	ocument the resid	h	scurrer	*	900	11
	status and whether There was no evide	any changes had	MC	urred.		İ	
	with the most recen	f dated 2/1/18		2 21 Lieu	1		
	The lack of docume		# 1	dedent	1		9, 5
	and/or changes in c	ondition and lack	bit a	anv	1	7	и
	recent progress no	tes from the prev	igu ₅	i la			
	months was confirm	ned and reviewed	dur	ing			
	interview with the or	wner on 7/17/18 a	5	PM.		por aug \$ 8.20.18	MBIRI
ivision of Li	censing and Protection					0.00	

Division of	Licensing and Pro	tection			34.		
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUP	ER	CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	DENTIFICATION	HUM	BER:	A. BUILDING:		COMPLETED
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		0619			B. WING		07/17/2018
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NAME OF PR	OVIDER OR SUPPLIER				arrown regularization arrows		
WINTERGR	REEN RESIDENTIA	L CARE - NORTH	11111		VN FARM RD DN, VT 05733		
CANADAMA WALESTANDING		·	-	-			CORPERTION OF
(X4) ID	SUMMARY STA	TEMENT OF DEFICIEN Y MUST BE PRECEDED	SES VF	lle.	ID PREFIX	 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT 	TION SHOULD BE COMPLETE
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFO	FMAT	(N)	TAG	CROSS-REFERENCED TO	
						DEFICIENC	,1)
R189 (Continued From pa	age 5	.		R189		
		-2			200000000000000000000000000000000000000	0.000	¥
F	Referalsó to R 150),				R 259;	-
						1 7 %	
	VII. NUTRITION AI	ND FOOD SERVI	PES		R259	ton actions	to von to corroct
SS=F					,	THE WITH	taken to correct
	77 0	and Fouriement			l î	the deficie	new is the
9	7.3 Food Storage	and Edinbuseur		0	1 -	The outlier	may 15 miles
	7.3 i Poisonous co	mpounds (such a		aning		facility u	Eleloans
	products and insec	ticides) shall be l	bele	d for	=	MUQUITY W	In ceaco
	easy identification	and shall not be s	Her be	in the	**	Davis	s compounds
1	food storage area	unless they are st	red	na	La	16012101000	3 WITTPOONES
		ompartment withi			3	LACKED SO	THE CLOSOT ON
	storage area.					100ku m	the closet an
		AND WENT WITHOUT MADE IN SO ST			1 :	not a nor a	uny food Storage
		NT is not met as	#Mq	enced	ļ ;	THO MELLI	and took south
	by:		M.L.	_{10.5}			<i>J</i>
		tion and staff interited to assure that			1	M. 40	and alaca
		cals were stored				mullsures (out into place
	locked compartme	ent in the food stor	Mol.	area	Ĭ		
ě	This finding had th	nt in the food stor e potential to affe		sidents	of!	are The M	anagorusil
	the facility. Finding	s include:		A STATE OF STATE AND AND AND ADDRESS OF A STATE OF STATE	.	0.001 0.00	
	The state of the s	9				PUST a rer	ninder for sta
		of the kitchen and			e	to lock of) 0 11 00 01 0
		the kitchen on the				W WILL M	au poisiona
	7/17/18, poisonous	s compounds incl	Mil.	pleaci			
	and clothes deterg	ent were stored u	Mdc.	eu, in		Compania	immediatu
	uie same area Will Regulatione requir	n canned and drie e that poisonous	MT.	NOUNTS		A GOV 11CA	a long in theme
	may only be store:	t in a food storage		a in a		MALLI MOL,	WOLLD WITHIN
5	separate locked co	ompartment. The	Han	ager		training an	Safety precau
	acknowledged the	error in storage d	ring	the	*		
	observations.	en engeneen untvolvetsendit/STREMINE		arc==-ax,		in a resider	Hial Cate home
						1 Table 1 Tabl	
R302	IX. PHYSICAL PLA	ANT			R302	0	11/11 2001120am
SS=D		nessus TS				Confective	medonies min
						no monital	od daw.
	9.11 Disaster and	Emergency Prep	m ed	ness		De HOME	measures will red daily.
		ni :				pc ant 8/20,	18. male -
Division of Lic	ensing and Protection				5.45.45.	100	
STATE FORM	E E				6893	97Ri11	if continuation sheet 6 of 8

Division	of Licensing and Pro							
	T OF DEFICIENCIES	(X1) PROVIDER/SUP	ER/	LIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	1
AND PLAN	OF CORRECTION	IDENTIFICATION	HOVE	ER:	A BUILDING:		COMPLETED	
							l c	
4		0619	11.		B. WING		07/17/2018	
					- 11			
NAME OF I	PROVIDER OR SUPPLIER	*	1000			STATE, ZIP CODE		.
WINTER	GREEN RESIDENTIA	CARE NORTH	1111 1		IN FARM RD		į	i
· · · · · · · · · · · · · · · · · · ·	OKEEN KEODEN IA	L OAKE - NOKIII	l I	RANDO	N, VT 05733			i
- (X4) IO	SUMMARY STA	TEMENT OF DEFICIEN	CIE\$		ID	PROVIDER'S PLAN OF CORRECTION	37.10 Til 10.00 to 10	
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED SC IDENTIFYING INFO	IN F	HAD THE	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		
TAG	REGULATOR OR E	SO IDENTIFY THAT IN O	M 7.,	"''	TAG ·	DEFICIENCY)	I KAIL	
			-		1	6 1 6 050		
R302	Continued From pa	ige 6			R302	Con+ 2259		
	9.11.c Each home	shall have in effect	ar	la e				0
	available to staff ar			111	i e	The doll correct	TIVE CLOODIN	17
	a plan for the prote	ction of all person	al ri	ne		True coore	Tibal I	
	a plan for the prote event of fire and fo	r the evacuation of	the	building		will be comple	that in 1	
	when necessary. A	Il staff shall be ins	truct	ed.		CONTRACTOR CONTRACTOR		
	periodically and ke	ot informed of their	n dut	es .	i	is August 13,8	2DIX. I	
	under the plan. Fire	drills shall be con	nduc	ed on		10-2000 1016	1	
	at least a quarterly	basis and shall ro	tate !	mes of	[i			
	at least a quarterly day among mornin	g, afternoon, even	ing,	nd	· ·	R 302		ĺ
	night. The date and					N 300		
	names of participat	ting staff members	skla	be				ĺ
	documented.					The action to	(0) to 1	
						THE WORLD TO		1
						correct the di	Fiction CU 1	
	This REQUIREME	NT in not mot an	بال ا	1	l :	Correct the w	arida 109	
	by:	ivi is not met as i	a vice	ceu		is to assure f	iro dedie	
	Based on staff inte	rview and record r	a via	the	ř			
						are cenducted	74100st	
	facility failed to ass conducted at least	quarterly and were	dta	led to				
	include the require	d times of the day,	in cli	uding	L	guartery & rot	of bolos	
	morning, afternoon	, evening and nigh	tir	es.	1:	7 us		
	Findings include:	98				morning, aftern	VERN UNDERNY	Ci.
*		2.000				morning, armar	1001, evening	
	Per review of the fi	re drills conducted	lill b	i \$ _		and nighttime	· Ω	
	previous 12 month drill conducted duri	period, there had	PP P	luo pre		iam morn una	9 4	
	omission was confi	ng the hight time t		ine				
	owner on 7/17/18 a		MY	Autri Die		IMAGELINGS DUT IN	1to 01000- 1	
	OWNER ON 17 (17) 10 6	11 4.55 1 141.				measures put in	- 1	
Paga	MICCELLANEOUS				Dann	is to post dock	15 + times 1	
SS≃C	MISCELLANEOUS	'			R999	10 10 1001 Cacio	Č! () 110	
	4 14 f The home s	hall make availabl				for Quarterly t	rearils!	
	4.14.f The home s reports resulting from			E I		Training,	0001100	O1C
	available to resider			nlace		where all sto	H+ Treside	(H)
	readily accessible t	o residents where	da	iduals.	8	000	1006/11	(2)
	wishing to examine	the results do not	Hav	e to asi	4	can read it c	reary 1	
	wishing to examine to see them. The h	ome must post a r	natio	of the			\cup	
	availability of such	reports. If a copy i	rec	vested			0 (00	
				Naccount of the		DC aunt 8.20.18	MBIR	

Division	of Licensing and Pro		Ш				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	5 (F)	RICLIA MBIER:	The second secon	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		0619			B. WING _		C 07/17/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET	ODRESS CITY	, STATE, ZIP CODE	
	GREEN RESIDENTIA	((*))		540 TOV	VN FARM RE	2	W.
/×4) ID	SI IMMA DV CY	ATEMENT OF DEFICIEN					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED SC IDENTIFYING INFO	H/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETE
R999	Continued From pa	age 7			: R999	CONT R302	
	and the home does					Λ ι	Lipaningon
	home must inform	the resident or ma	t h	er of the	ł	Corrective my	MCAMBON
	public that they ma licensing agency a	y request a copy		h the	1	las has 11 sas	1 200 21/11
	tolenhana number	nd provide the add		sland		be monitore	a monthinal
	telephone number	or the licensing at	1111	-XI		I have some or	inac J
	Based on observat	ion and staff inter	,	v lihe		by the mano	WU.
	home failed to pos	and provide a rea			100		V .
34	home failed to positive available copy of the	ne most recent sur	Wey	report		Dra dall con	55 55 1 111
	for residents and the	ne public to read.	Hihi	ings	i	The double con	
	include:				:	action will	ha complat
	1 - 1000	manager of the control of the control of	Щ_				
	Per observations o	n the morning of		/218		Is August 1	3,2018
	during the re-licens	a notice of the au		naa noo		10 ragues c	010010
	posted a copy, hor the most recent su	nev report for inte		to d	l .	1.	
	residents and the p	public to read. Dur		interview			
	at the time of the o	bservation, the ow		- III	i	0.000	6 :
	confirmed that s/he	had not been aw	8	dithe		The Correction	2001-120 o
	requirement to pos	t, or have readily	Na	lable a	ŀ	the Correctiv	e actions
	notice of the survey	y results for review	by			Measures Po	H into place
	interested resident	s and the public.	1			1 the market of be	Wi him pion
					•	So this does	al more ro
						• Control of the cont	2 Pl (2) (2) (2) (2) (2) (2) (2) (2) (2) (2)
				-		Post all wr	then woon
						trom inspect	imas readil
		Sel (I)				CANO, JOHN	YOUR LCAULT
		140		1 11		aranable to	residonis
						and de was	
						will to the	DUDITE.
	72) : 	halfolian 1:	-Va'- 20-11
						and to the wishing to e	EXAMINET
	* .	(6)				12 LL 201	2
					100	results, Acount 8.20.18	
					1		
	a	2				Ac must 8.20.18	m2/6/
						The second of the	1 10/0
Sion of Li-	ensing and Protection		A				
TE FORN					8822	97RI11	W 325 (001 56) *A

Wintergreen Residential Care - North Resident Identifier Health Survey July 17, 2018

Con+ R9991

measures put into place. So this deficiency devent recur is the manager will post all written reports from a inspection and leave it up for review until the next inspection.

The Corrective actions will be monistored by the Dwner So this does not recur.

The corrective action to the corrective date action will be completed is August 13,2018,

so cant 8.20.8 mg.sl